

Utah Summit on Health Insurance Coverage for the Uninsured

Staff Working Paper

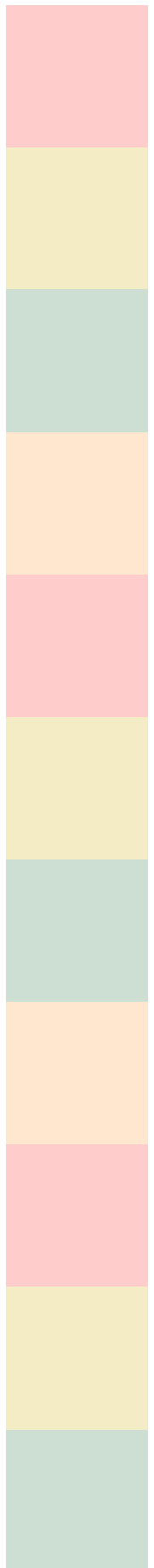
Prepared for

David N. Sundwall, M.D.
Executive Director
Utah Department of Health

D. Kent Michie
Commissioner
Utah Department of Insurance

Richard J. Sperry, M.D., Ph.D.
Director
Governor Scott M. Matheson Center for Health Care Studies
University of Utah

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I. Utah's Past Accomplishments

Excerpts from the UDOH Application for State Planning Grant—Covering the Uninsured of Utah

With an uninsured rate of approximately 10.2%, Utah has a compelling opportunity to create one of the lowest uninsured rates in the U.S. Utah has a long history of collaborative efforts to improve access to health care for its indigent and uninsured populations. The establishment of the Utah Medical Assistance Program (UMAP) in 1983 and the Utah Comprehensive Health Insurance Pool in 1990 are examples of these efforts. The first significant state executive effort to expand access to health coverage took place during the Leavitt administration with the creation of the Utah Health Policy Commission (HPC). Over the course of its tenure, the HPC recommended and supported the passage of 20 pieces of legislation that directed the state's efforts to improve health access and coverage for the uninsured including:

- *Health Systems Improvement Act*. Medical Savings accounts become effective retroactively after January 1, 1995.
- *Voluntary Health Insurance Purchasing Alliance Act*. Allows the creation of voluntary health insurance purchasing alliances.
- *Open Enrollment Amendments*. Modify the eligibility requirements and premium rates for comprehensive health pool; authorize coverage for individuals whose health conditions do not meet insurance pool criteria.
- *Children's Health Insurance Program (CHIP)*. A state program that has an enrollment of nearly 29,000 children and expects to expand to 40,000 in 2005.

After the Commission was disbanded in 2000, the Utah Department of Health undertook a planning study to determine what further actions were needed to address the issue of health coverage for Utah's low-income individuals. As a result of the study, the state applied and was granted a Medicaid waiver to create the Primary Care Network (PCN). PCN provides access to medical care for around 19,000 low-income adults who do not qualify for Medicare or Medicaid and do not have access to private insurance. In connection with the waiver, Governor Leavitt signed HB 122 enabling commercial carriers to offer private employers a basic primary care package similar to PCN, presumably at a low cost. Other collaborative projects throughout the state provide services for the uninsured include:

- **Community Health Centers (CHC)**: located at 22 different sites throughout Utah, CHCs provide primary care to individuals who have inadequate or no access to health care.
- **University of Utah Hospital and Clinics**: provides \$30 million of uncompensated charity care to the indigent and uninsured on an inpatient and outpatient basis.
- **Dental Services**: provided by CHCs, Primary Children's Hospital, University of Utah Dental Clinic, and two volunteer agencies, Donated Dental and Dental House Calls.

Other policy groups such as the Governor Scott M. Matheson Center for Health Care Studies and the Utah Health Alliance have conducted discussions and studies in the past to bring Utahns from academia, medicine, and health economics together to study potential solutions.

II. State Options for Covering the Uninsured

Staff commentary, with state program information excerpted from State of the States: Finding Alternate Routes, January 2005, published by The Robert Wood Johnson Foundation's State Coverage Initiatives and Academy Health.

In the past few years there has been significant interest by states to adopt creative solutions to providing health coverage and access to the uninsured. Some states have embarked on comprehensive reforms while others prefer incremental proposals, such as enhancing the private sector, expanding the role of the public sector, and partnering with community-based programs. During this period there has also been some interest from the private sector in new types of private insurance products that promote cost savings and consumer-driven approaches.

Comprehensive Reforms

- **Massachusetts' "Commonwealth Care"** – The strategy includes four market-based strategies, including: (1) eliminating insurance mandates to entice small businesses to offer insurance and penalize firms that fail to offer coverage, (2) reach out to Medicaid-eligible but unenrolled citizens, (3) replace the uncompensated care pool with a managed treatment system called Safety Net Care, and (4) expand the duration of coverage the state offers to unemployed workers.
- **Maine's "Dirigo" Plan** – Maine will ensure access to coverage to ... small-business employees, the self-employed, and individuals.... The state expanded MaineCare under its existing waiver authority.... A second component of Dirigo is a public/private health plan called DirigoChoice, which is intended for businesses of 2 to 50 employees, the self-employed, and unemployed or part-time workers. Dirigo provides sliding-scale premium discounts ... to enrolled individuals and families based on their ability to pay.... After the first year of DirigoChoice, Maine officials plan to charge insurance companies an annual assessment not to exceed 4 percent of their premiums.
- **Single Payer Plans**

Partnering With the Private Sector

- **Small Business "Buy-in" to Public Programs** – Some proposals would allow businesses who employ low-wage workers or that have not been able to offer insurance to "buy-in" to public programs at an actuarially determined rate. These premiums would be lower than private insurance because of Medicaid's discounts to providers. This could create "reverse" incentives for employers in the private market to drop coverage with the intent of "buying-in" down the road, although this is debatable.
Example: **West Virginia** created a public/private partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies. The private carriers will be given access to PEIA's reimbursement rates, enabling them to sell coverage that is more affordable. The coverage plan will be open to small businesses with 2 to 50 employees with no coverage for 12 consecutive months.
- **State as Re-insurer** – The state would provide reinsurance services to private insurers, providing some stability to the insurance market and perhaps encourage entry and innovation in insurance products. "Both **Arizona** and **New York** operate subsidized reinsurance programs, with the latter program enrolling almost 76,000 workers and their dependents.

Kansas ... has proposed using reinsurance to provide an affordable insurance product to small employers.”

- **Collective Purchasing or Voluntary Insurance Pools** – Several proposals would facilitate individuals, small business, the self-employed, and others to participate in purchasing cooperatives. This option often includes a recommendation for premium subsidies for low- and middle-income people. Adverse selection would almost certainly make such a state subsidy very large, but could potentially reduce premiums for private insurers.
- **Premium Subsidies** – State or community funds would subsidize employer-sponsored health insurance.
Examples: **Michigan** offers beneficiaries with access to employer-sponsored insurance a voucher that is equal in value to the state’s cost of providing service. In **Idaho**, parents with SCHIP qualified children have a choice for that coverage between a state-sponsored direct benefit program or a premium assistance program. Unlike traditional premium assistance programs, **New Mexico**’s program creates a new insurance product for small employers.
- **Refundable Tax Credits** – Credits would be given to individuals that purchase private individual or group coverage. This is intended to offset the tax subsidy given to employer-sponsored premiums and is often discussed as a federal reform. However, at the state level it is possible to create credits to offset the cost of purchasing individual coverage. The primary issue is cost.
- **Three-share Model (Muskegon Co., Michigan)** – This program is a version of premium subsidies that uses community health resources (DSH or CHC funding) to contribute about one third of the cost of employer-sponsored premiums. Employees and employers share the remaining costs. In some cases, this type of plan uses the CHC system as the source of primary care. Similar models are being developed and/or implemented in ... **Arkansas, Florida, Illinois, Iowa, Louisiana, Maryland, Virginia, and West Virginia.**
- **“Pay or Play” Programs** – These programs require employers to either contribute to employee premiums or to a state fund to cover the uninsured. The issue here is to remember that it is ultimately the employees that would pay for this program in the form of lower wages. **California** voters rejected a pay or play ballot initiative in 2004.

Innovative Insurance Products/Options

- **Health Savings Accounts (HSA)** – As a companion to catastrophic coverage this is a tax-favored vehicle for financing routine or non-catastrophic health care needs. HSAs can be funded through individual, employer, or third-party contributions.
- **Catastrophic Coverage** – High deductible insurance or health plans may be a beneficial and cost-effective option for the uninsured: as more employers offer them as an option, the low monthly premiums may increase the fraction of the employed with insurance. Some catastrophic plans also include full coverage for preventive care. These could be an option for expanding state-sponsored coverage if accompanied by HSA.
- **Limited Benefit Coverage (LBC)** – Private insurers could offer reduced benefit plans to individuals and employers. LBCs may provide coverage for basic services, but not insurance for high-cost conditions or events. State coverage mandates may limit the ability of insurers to offer more affordable options to employers.
Example: **New Jersey**’s Individual Health Coverage program (IHC) and the Small Employer Health Benefits program (SEH) have been reported to be “modestly effective in increasing enrollment and reducing the number of uninsured in the state.”

Solutions Involving Public Programs

- **Expanding existing programs** – One approach to covering the uninsured is to expand Medicaid or CHIP programs. The major drawback is cost. An alternative is to reduce the level of benefits to the current enrollees in order to provide benefits to additional populations.
- **Outreach to “eligible but not enrolled” population** – This is a key component of several state initiatives. The obvious advantages of using an existing system are offset by the unknown likelihood of success and the increased cost to existing programs if successful.
- **Increase access to basic services through CHCs or Public Clinics** – Strengthening the safety net does not provide insurance, per se, but would ensure access to basic services.
- **State-sponsored High Risk Pools** – Some of the uninsured are “uninsurable” meaning that no private insurance plan will accept them. It is possible to evaluate the role and success of the state Health Insurance Pool (HIP) in providing a meaningful insurance opportunity. The main issue with expanding HIP is cost.

Community-level Initiatives

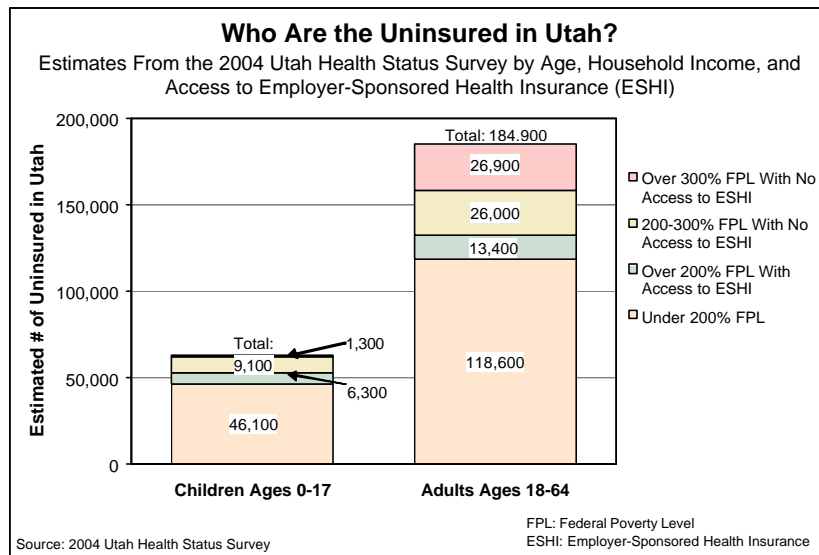
- “At least 20 states have organized community-based systems of care for the uninsured. Such programs are financed through various federal and state sources as well as Medicaid funds, local government finances, local employer assets, family contributions, and philanthropy.”
- Some examples include programs that provide reduced-fee or free care through community health centers, provide commercial insurance plans to low-income workers or small businesses at a reduced cost, establish medical homes for the uninsured, or use managed care or case management to help high-utilizing uninsured or indigent populations.
- The Health Resources and Services Administration (HRSA)’s Community Access Program (CAP) funds community solutions to access issues related to the uninsured. Currently, CAP grants support 158 communities as they work to coordinate “safety net” services for uninsured and underinsured Americans. Under CAP, “communities receiving continuing funds continued to demonstrate varied and innovative achievements in building integrated health care delivery systems that offer a comprehensive continuum of care and increase the number of low-income, uninsured and underinsured people with access to health services.”
- Funding sources include county tax revenues, in-kind services, DSH funding, CAP grants, tobacco settlements, employer and employee contributions, state and federal matching funds, and philanthropic sources.

III. How Many Uninsured Utahns Could Benefit From These Proposals?

In order to assist in the policy discussion, it is important to keep in mind who the uninsured in Utah are and how their needs may be addressed, possibly through diverse options. Recent estimates from the Utah Department of Health’s *Health Status Survey* help to highlight the nature of the problem.

- **Low income households** – Around 73% of uninsured children and 64% of uninsured adults are in households with incomes below 200% of the federal poverty level (FPL), about \$37,700 for a family of four. This would make them eligible for current state programs (Medicaid, PCN, CHIP, or service at Federally Qualified Health Centers). Many in this category could enroll in existing public programs. For these, a key issue is to understand why they do not enroll. Some in this group have access to insurance through an employed family member, but do not sign up, in many cases due to concerns over cost. It should also be noted

that many in this group do not qualify for public programs based on immigrant status. In this case, the primary means of receiving care is through publicly funded health centers. Consideration could be given to increased funding for public clinics as a means of addressing the health care needs of this population.



- **Access through employment** – 20% of uninsured adults and 38% of uninsured children in households with incomes over 200% of the FPL have access to employer-sponsored health insurance (ESHI). This population could benefit from policies that strengthen the employer-based system.
- **Moderate income, but no access through employment** – 15% of uninsured children and 15% of uninsured adults are in households with incomes between 200% and 300% of the FPL and have no access to ESHI. For families in this group, buying insurance from the commercial market might be the only option, although some may find it difficult to afford individual coverage. A family of four in this group would have an income in the \$37,700-\$56,550 range. *This should be a high priority group.*
- **Undocumented immigrants** – Estimates of the size of this population are not very reliable, not to mention how difficult it is to know what their incomes or insurance status are. It may very well be the case that many of the uninsured below 200% of the FPL are undocumented immigrants, but we do not have good evidence on this issue.

IV. Summary

The state of Utah has made good progress in making health insurance coverage available. However, rising costs of private insurance and other factors have led to recent increases in the percentage of Utahns without health insurance. Several groups have worked hard to identify the nature of the problem and potential solutions. By building on this effort and knowledge base, coupled with the experiences of other states who are wrestling with the problem, it is hopeful that Utah's health policy makers can find real solutions that will work in Utah.

Sources:

- Austin, Bonnie, et al. January 2005. *State of the States: Finding Alternate Routes*. Published by The Robert Wood Johnson Foundation's State Coverage Initiatives and Academy Health.
<http://www.statecoverage.net/pdf/stateofstates2005.pdf>
- Nichols, Len M. March 9, 2004. *Myths about the Uninsured*. Statement before the U.S. House of Representatives Committee on Ways and Means Health Subcommittee.
http://www.umich.edu/~eriu/pdf/nichols_testimony.pdf

Sheils, John, and Randall Haight. October 2003. *Covering America: Real Remedies for the Uninsured— Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage*. Report on *Covering America*, a grant funded by the Robert Wood Johnson Foundation. Published by The Lewin Group.

Sperry, Richard J. September 30, 2004. *Moving Forward: Next Steps in Covering Utah's Uninsured*. PowerPoint Presentation.

Contributing Staff:

Deborah Turner, Director , Government and Professional Relations

Norman Thurston, Research Consultant, Health Care Financing

Lois Haggard, Director, Office of Public Health Assessment

Barry Nangle, Director, Center for Health Data

Wu Xu, Director, Office of Health Care Statistics